Alabama Christian Athletic Association

Medical History / Physical Form

HISTORY Date_____

Name_____ Sex _____ Age _____ Date of Birth_____

Address _____ Phone _____

School _____Grade_____ Sport_____

Check Yes or No

Explain "Yes" answers below:	**Yes √**	**No √**
1. Has a doctor ever restricted/denied your participation in sports?		
2. Have you ever been hospitalized or spent a night in a hospital?		
Have ever had surgery?		
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?		
4. Are you presently taking any medications or pills (prescription or over-the-counter)?		
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?		
6. Have you ever passed out during or after exercise?		
Have you ever been dizzy during or after exercise?		
Have you ever had chest pain or discomfort in your chest during or after exercise?		
Do you tire more quickly than your friends during exercise?		
Have you ever had high blood pressure?		
Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?		
Have you ever had racing of your heart or skipped heartbeats?		
Has anyone in your family died of heart problems or a sudden death before age 50?		
Does anyone in your family have a heart condition?		
Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?		
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?		
8. Have you ever had a head injury or concussion?		
Have you ever been knocked out or unconscious?		
Have you ever had a seizure?		
Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?		
9. Have you ever had heat or muscle cramps?		
Have you ever been dizzy or passed out in the heat?		
10. Do you have trouble breathing or do you cough during or after activity?		
Do you take any medication for asthma (for instance, inhalers)?		
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?		
12. Have you had any problems with your eyes or vision?		
Do you wear glasses or contacts or protective eye wear?		
13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?		
14. Have you had a medical problem or injury since your last evaluation?		
15. Have you ever been told you have sickle cell trait?		
Has anyone in your family had sickle cell disease or sickle cell trait?		
16. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ( ) Head ( ) Back ( ) Shoulder ( ) Forearm ( ) Hand ( ) Hip ( ) Knee ( ) Ankle ( ) Neck ( ) Chest ( ) Elbow ( ) Wrist ( ) Finger ( ) Thigh ( ) Shin ( ) Foot		
17. When was your first menstrual period? _____ **When was your last menstrual period?** _____ **What was the longest time between your periods last year?** _____		
Explain "Yes" answers:		

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of athlete _____ Date _____

Signature of parent/guardian _____

In order for any student to be eligible for interscholastic athletics, there must be on file in your school's office a current Medical History Form (signed by a physician) certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics. **A physical exam will satisfy the requirement for one calendar year from the date of the exam.**

PHYSICAL EXAMINATION

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision R 20/_____ L 20/_____ Corrected: Yes or No

	Normal	Abnormal Findings
Cardiovascular		
Pulses		
Heart		
Lungs		
Skin		
E.N.T.		
Abdominal		
Genitalia (males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not cleared for: **( )** Collision **( )** Contact

( ) Non-contact _____ Strenuous _____ Moderately strenuous _____ Non-strenuous

Due to: _____

Recommendation: _____

_____

_____

Name of physician _____ Date _____

Address _____ Phone _____

Signature of physician _____, M.D. or D.O.

(This form must be signed and dated by the attending physician.)